

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4419

CERTIFICATE OF DEATH

Reg. Dist. No. 265

04414

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>since birth</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LINDA</b> Middle <b>JOYCE</b> Last <b>ABBOTT</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1956</b>
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harold Abbott</b>		14. MOTHER'S MAIDEN NAME <b>Mae Rich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Albert Rich</b>		Address <b>Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> DUE TO <b>761.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Paralysis of Cord</b> DUE TO (c) <b>Breech Presentation</b>			INTERVAL BETWEEN ONSET AND DEATH <b>52 hours</b> <b>52 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 13, 1956</b> to <b>April 15, 1956</b> , that I last saw the deceased alive on <b>April 15, 1956</b> , and that death occurred at <b>6:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr</b>		ADDRESS (Street, city or town, state) <b>Crisfield, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>As N. Barr</b>		DATE SIGNED <b>4/16/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 16, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rich Family Cemetery</b>
22d. LOCATION (City, town, or county) (State) <b>near Crisfield, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>April 16, 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. ABBOTT		SEX Male		AGE 45	
DATE OF DEATH April 1, 1956		PLACE OF DEATH Home		CITY Boston	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 100-100000	
DATE OF BIRTH April 1, 1911		PLACE OF BIRTH Boston		CITY Boston	
FATHER'S NAME John J. Abbott		MOTHER'S NAME Mary E. Abbott		CITY Boston	
OCCUPATION None		EDUCATION None		RELIGION None	
MARITAL STATUS Married		PREVIOUS MARRIAGES None		DATE OF MARRIAGE None	
DATE OF INTERVIEW April 1, 1956		INTERVIEWER None		SIGNATURE None	
DATE OF DEATH April 1, 1956		PLACE OF DEATH Home		CITY Boston	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 100-100000	
DATE OF BIRTH April 1, 1911		PLACE OF BIRTH Boston		CITY Boston	
FATHER'S NAME John J. Abbott		MOTHER'S NAME Mary E. Abbott		CITY Boston	
OCCUPATION None		EDUCATION None		RELIGION None	
MARITAL STATUS Married		PREVIOUS MARRIAGES None		DATE OF MARRIAGE None	
DATE OF INTERVIEW April 1, 1956		INTERVIEWER None		SIGNATURE None	

RECEIVED  
APR 19 1956  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

## CERTIFICATE OF DEATH

04415

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> 39	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		d. STREET ADDRESS <b>near Sackertown Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALTON</b> Middle <b>MAYNARD</b> Last <b>ADAMS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1908</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cutlery Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James H. Adams</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-05-7000</b>	
17. INFORMANT <b>Mrs. Ruby M. Adams-Crisfield, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>14 months</b> (c) <b>14 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Slightly overweight</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 19</b> , 19 <b>56</b> , to <b>April 19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 19</b> , 19 <b>56</b> , and that death occurred at <b>3:30</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr</b>		M.D. <b>Crisfield, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>		Main St.--Crisfield, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 22, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 4/27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Bastard S. Adams</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF NEXT OF KIN [Illegible]		ADDRESS OF NEXT OF KIN [Illegible]		CITY AND STATE OF NEXT OF KIN [Illegible]	
NAME OF DECEASED'S MOTHER [Illegible]		NAME OF DECEASED'S FATHER [Illegible]		NAME OF DECEASED'S SPOUSE [Illegible]	
NAME OF DECEASED'S BROTHER [Illegible]		NAME OF DECEASED'S SISTER [Illegible]		NAME OF DECEASED'S CHILDREN [Illegible]	
NAME OF DECEASED'S GRANDFATHER [Illegible]		NAME OF DECEASED'S GRANDMOTHER [Illegible]		NAME OF DECEASED'S UNCLE [Illegible]	
NAME OF DECEASED'S AUNT [Illegible]		NAME OF DECEASED'S NEPHEW [Illegible]		NAME OF DECEASED'S NIECE [Illegible]	
NAME OF DECEASED'S COUSIN [Illegible]		NAME OF DECEASED'S FIRST COUNSELOR [Illegible]		NAME OF DECEASED'S SECOND COUNSELOR [Illegible]	
NAME OF DECEASED'S THIRD COUNSELOR [Illegible]		NAME OF DECEASED'S FOURTH COUNSELOR [Illegible]		NAME OF DECEASED'S FIFTH COUNSELOR [Illegible]	
NAME OF DECEASED'S SIXTH COUNSELOR [Illegible]		NAME OF DECEASED'S SEVENTH COUNSELOR [Illegible]		NAME OF DECEASED'S EIGHTH COUNSELOR [Illegible]	
NAME OF DECEASED'S NINTH COUNSELOR [Illegible]		NAME OF DECEASED'S TENTH COUNSELOR [Illegible]		NAME OF DECEASED'S ELEVENTH COUNSELOR [Illegible]	
NAME OF DECEASED'S TWELFTH COUNSELOR [Illegible]		NAME OF DECEASED'S THIRTEENTH COUNSELOR [Illegible]		NAME OF DECEASED'S FOURTEENTH COUNSELOR [Illegible]	
NAME OF DECEASED'S FIFTEENTH COUNSELOR [Illegible]		NAME OF DECEASED'S SIXTEENTH COUNSELOR [Illegible]		NAME OF DECEASED'S SEVENTEENTH COUNSELOR [Illegible]	
NAME OF DECEASED'S EIGHTEENTH COUNSELOR [Illegible]		NAME OF DECEASED'S NINETEENTH COUNSELOR [Illegible]		NAME OF DECEASED'S TWENTIETH COUNSELOR [Illegible]	

RECEIVED  
 APR 30 1956  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05479

4421

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		e. STREET ADDRESS <b>near Sackertown Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>HILDA</b> Middle <b>WESLEY</b> Last <b>BUTLER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1903</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR: Months <b>53</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Moore</b>		14. MOTHER'S MAIDEN NAME <b>Alice Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Clarence G. Butler, Sr.-Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>260X</b> DUE TO (b) <b>Diabetic Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>Severe Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>8 years</b> <b>8 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Sclerosis of Metatarsal Arches; Osteomyelitis of Metatarsal</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 11, 1953</b> , to <b>April 26, 1956</b> , that I last saw the deceased alive on <b>April 26, 1956</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr</b>		ADDRESS (Street, city or town, state) <b>530 W. Main St. Crisfield</b> DATE SIGNED <b>4/26/56</b>	
PHYSICIAN'S NAME (Type) <b>A. N. Barr</b>		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons-Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>May 17 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>	



RECEIVED

MAY 21 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4422

## CERTIFICATE OF DEATH

04416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>Vina</b> Last <b>Carter</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 22, 1880</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William James Ross</b>				14. MOTHER'S MAIDEN NAME <b>Susan Francis Beaubhamp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <b>Chester A. Carter, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cardio-Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> (c) <b>15 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 to 5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1st, 1956</b> to <b>April 1, 1956</b> , that I last saw the deceased alive on <b>April 1st, 1956</b> and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							DATE SIGNED <b>4/5/56</b>
ACTUAL SIGNATURE <b>N. E. Sartorius</b>		M.D. <b>Pocomoke City Md</b>		ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <b>N. E. Sartorius, Sr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Emanuel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>RURAL Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 29 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Orville Boyman</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

1955

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. SIGNATURE OF DECEASED [REDACTED]		11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF PHYSICIAN [REDACTED]	
13. SIGNATURE OF CLERK [REDACTED]		14. SIGNATURE OF REGISTRAR [REDACTED]		15. SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. S.

APR 9 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4423

## CERTIFICATE OF DEATH

04417

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Vernon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Vernon</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W</u> Last <u>Washell</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17 1862</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTH PLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Peter Washell</u>		14. MOTHER'S MAIDEN NAME <u>Betty Simpkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Washell, Mt Vernon md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>55</u> , to <u>April 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>56</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Everett C Sutter</u> M.D.		<u>DAMES GUARANTY, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Everett C Sutter</u>		<u>DAMES GUARANTY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Vernon md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hinman Thiverson</u> ADDRESS <u>Hennock Rd</u>		24a. REC'D BY REGISTRAR <u>4/20/56</u> 24b. REGISTRAR'S SIGNATURE <u>R. D. Johnson, M.D.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. 51

APR 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05483

4424

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>		d. STREET ADDRESS <b>227 W. Main St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		39	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ELIJAH</b> Last <b>GODMAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1867</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Edward Godman</b>		14. MOTHER'S MAIDEN NAME <b>Frances Isabelle Lankford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Wm. H. Coulbourn—Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 5</b> , 19 <b>56</b> , to <b>Apr 26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Apr 25</b> , 19 <b>56</b> , and that death occurred at <b>10:45</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b>		ADDRESS (Street, city or town, state) <b>336 Main St. Crisfield, Md.</b>	
DATE SIGNED <b>4/28/56</b>		PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 29, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>May 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Barton J. Adams</b>	

CERTIFICATE OF DEATH

PLACE OF BIRTH BALTIMORE		DATE OF BIRTH MAY 21 1956	
PLACE OF DEATH BALTIMORE		DATE OF DEATH MAY 21 1956	
NAME OF DECEASED JAMES EARL RAY		SEX MALE	
RACE WHITE		AGE 37	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION None		RELIGION None	
CAUSE OF DEATH Suicide by gunshot		MANNER OF DEATH Suicide	
PLACE OF DEATH Room 101, Federal Bureau of Investigation Building		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF DECEASED JAMES EARL RAY	
DATE MAY 21 1956		TIME 10:00 AM	
PLACE OF BIRTH BALTIMORE		DATE OF BIRTH MAY 21 1956	
PLACE OF DEATH BALTIMORE		DATE OF DEATH MAY 21 1956	
NAME OF DECEASED JAMES EARL RAY		SEX MALE	
RACE WHITE		AGE 37	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION None		RELIGION None	
CAUSE OF DEATH Suicide by gunshot		MANNER OF DEATH Suicide	
PLACE OF DEATH Room 101, Federal Bureau of Investigation Building		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF DECEASED JAMES EARL RAY	
DATE MAY 21 1956		TIME 10:00 AM	

RECEIVED  
MAY 21 1956  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04418

4417

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 N. 4th St.</b>		d. STREET ADDRESS <b>106 N. 4th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>DELLA</b> Middle <b>PHILLIPS</b> Last <b>HOLLAND</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1884</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crabs &amp; Oysters</b>	11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hester Phillips</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>218-03-3289</b>		17. INFORMANT <b>Charles Holland-106 N. 4th St.-Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Died During Sleep arteriosclerosis</b> 260 X DUE TO <b>History of Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>no</b> o. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>She was dead before I was called</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>William H. Coulbourn</b> M.D.		ADDRESS (Street, city or town, state) <b>Crisfield Md</b> DATE SIGNED <b>4. 11. 56</b>	
PHYSICIAN'S NAME (Type) <b>William H. Coulbourn</b>		Main St.-Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 5, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons-Crisfield, Maryland</b>		ADDRESS <b>Bradshaw &amp; Sons-Crisfield, Maryland</b>	
24a. REC'D BY REGISTRAR <b>April 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara A. Adams</b>	



BUREAU V. S.

APR 12 1956

RECEIVED

4425

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Since birth</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCreedy Hospital</b>				d. STREET ADDRESS <b>McCreedy Hospital</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NELSON</b> Middle <b>KIRK</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1956</b>	
9. AGE (In years last birthday) <b>0</b>		IF UNDER 1 YEAR <b>0</b> Months <b>0</b> Days		IF UNDER 24 HRS. <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Frank Goldburn Lee</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Ridgell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ruth Lee-Maple &amp; First St.-Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>760.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Apr. 19, 1956</b> to <b>Apr. 25, 1956</b> that I last saw the deceased alive on <b>Apr. 25, 1956</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.				ADDRESS (Street, city or town, state) <b>33 W. Main Crisfield, Md.</b> DATE SIGNED <b>4/25/56</b>			
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton</b>				Main St.—Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 25, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>4/27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Barton S. Adams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4426

### CERTIFICATE OF DEATH

04420  
Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>				c. LENGTH OF STAY IN 1b <b>Since 1903</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crisfield</b>				d. STREET ADDRESS <b>Crisfield</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>ELIZABETH</b> Last <b>MORRIS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1882</b> <b>January 18, 1882</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John W. Dryden</b>				14. MOTHER'S MAIDEN NAME <b>Mary P. Dickerson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>George Morris--R.F.D. Crisfield, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute dil. of heart - Uremia</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis - Chronic Int. Nephritis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>27 days</b> <b>yes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 22, 1956</b> , to <b>Apr. 17, 1956</b> , that I last saw the deceased alive on <b>Apr. 17, 1956</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George C. Coulbourn</b>				ADDRESS (Street, city or town, state) <b>Marion Sta., Md.</b>			
DATE SIGNED <b>4-19-56</b>							
PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M. D.</b>				Marion Station, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4-19-56</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie D. Payne</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
LOCALITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF HEALTH		U.S. GOVERNMENT PRINTING OFFICE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: Prior to this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04421

4427

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mae</b> Last <b>Outen</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1893</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cottage Grove</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Fontaine</b>		14. MOTHER'S MAIDEN NAME <b>Esther Tunnel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-22-6295</b>	
17. INFORMANT <b>Anna Mae Collins-Westover, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF CERVIX UTERUS</b> <b>4 YEARS +</b> (c) <b>WITH 'FROZEN PELVIS'</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OBESITY ; HYPERTENSION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 10, 1955</b> , to <b>4-23-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-21</b> , 19 <b>56</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>Geo M Dunn</b> M.D. PHYSICIAN'S NAME (Type) <b>GEORGE MITCHELL DUNN, M.D.</b> <b>Princess Anne, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 25, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cottage Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Westover, Som. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward-Marion Station, Md.</b>		24a. REC'D BY REGISTRAR <b>4/29/56</b>	
ADDRESS <b>2</b>		24b. REGISTRAR'S SIGNATURE <b>R. A. Johnson, M.D.</b>	

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*(Handwritten signature)*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, state exact date the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Child Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04422

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>M.</b> Last <b>Shreeves</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1923</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westover, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry McKinley Shreeves</b>		14. MOTHER'S MAIDEN NAME <b>Ollie Collins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W. War II</b>		16. SOCIAL SECURITY NO. <b>220-12-0710</b>	
17. INFORMANT <b>Ollie Shreeves - Westover, Md. - Somerset Co.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 23-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cottage Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westover, Somerset Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion Sta, Md</b>	
24a. REC'D BY REGISTRAR <b>4/23/56</b>		24b. REGISTRAR'S SIGNATURE <b>R. H. Johnson, M.D.</b>	

BUREAU V. S.

APR 25 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4418

## CERTIFICATE OF DEATH

04423

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Jacksonville Rd.				d. STREET ADDRESS Jacksonville Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JULIA Middle ANNIE Last SOMERS				4. DATE OF DEATH Month April Day 17 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1872	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Smith Ward				14. MOTHER'S MAIDEN NAME Julia A Pruitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Dr. Grover S. Somers--Marion Station, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis (c) Neglect of Colon - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1956 to April 17, 1956, that I last saw the deceased alive on April 17, 1956, and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sarah M. Peyton M.D. Crisfield, Md. - April 21, 1956 PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D. Main St.--Crisfield, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 4/27/56		24b. REGISTRAR'S SIGNATURE Barton S. Adams	



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04424

## 4429 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>SOMERSET</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DEAL ISLAND</u>		LENGTH OF STAY (in this place) <u>36 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DEAL ISLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AT HOME</u>				STREET ADDRESS (If rural give location) <u>—</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) (Type or Print) <u>EDNA BELL TWIGG</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>APRIL 17 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 25 - 1903</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CRAB-SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>CHANCE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT J. GREEN</u>				14. MOTHER'S MAIDEN NAME <u>LULY POPE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unk.)) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-22-8245</u>		17. INFORMANT & ADDRESS <u>GILLIS TWIGG - DEAL ISLAND MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Heart Disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acute Tonsillitis</u>						<u>5 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-2</u> , 19 <u>55</u> , to <u>4-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>56</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Everett C. Smith M.D.</u>				ADDRESS (Street, city, town, state) <u>Danvers Quarter Md.</u>		DATE SIGNED <u>4/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4-20-56</u>	NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS M.E.</u>		LOCATION (City, town, or county) (State) <u>DEAL ISLAND MD</u>			
24. REC'D BY REGISTRAR <u>7/23/56</u>	REGISTRAR'S SIGNATURE <u>Lela J. Wheately</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. D. Webster</u>		ADDRESS <u>Deal Island</u>		

INSTRUCTIONS

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form 100-10-1

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH May 1, 1956		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Coronary Thrombosis		8. MANNER OF DEATH Natural	
9. SIGNATURE OF PHYSICIAN J. J. Henry		10. SIGNATURE OF REGISTRAR J. J. Henry	
11. SIGNATURE OF DECEASED J. J. Henry		12. SIGNATURE OF WITNESSES J. J. Henry	
13. SIGNATURE OF FUNERAL HOME J. J. Henry		14. SIGNATURE OF BURIAL PLACE J. J. Henry	
15. SIGNATURE OF CEMETERY J. J. Henry		16. SIGNATURE OF INTERMENT J. J. Henry	
17. SIGNATURE OF CREMATION J. J. Henry		18. SIGNATURE OF DISPOSITION J. J. Henry	
19. SIGNATURE OF OTHER J. J. Henry		20. SIGNATURE OF OTHER J. J. Henry	
21. SIGNATURE OF OTHER J. J. Henry		22. SIGNATURE OF OTHER J. J. Henry	
23. SIGNATURE OF OTHER J. J. Henry		24. SIGNATURE OF OTHER J. J. Henry	
25. SIGNATURE OF OTHER J. J. Henry		26. SIGNATURE OF OTHER J. J. Henry	
27. SIGNATURE OF OTHER J. J. Henry		28. SIGNATURE OF OTHER J. J. Henry	
29. SIGNATURE OF OTHER J. J. Henry		30. SIGNATURE OF OTHER J. J. Henry	
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